TWIGGE ORTHODONTICS

NEW PATIENT INFORMATION

PATIENT INFORMATION

Person completing this form:	Relationship to patient:
Patient full name:	Patient date of birth:
Occupation/School:	

CORRESPONDENCE AND ACCOUNTS

Miss/Ms/Mrs/Mr:	Relationship to patient:
Physical address:	Post Code:
Postal address:	Post Code:
Best personal contact number:	
Work contact number:	
Best email address:	
Emergency contact person and number:	

HEALTH FUND

Name of Health Fund:

GENERAL

How did you hear about TWIGGE ORTHODONTICS?
Referring dentist:
Reason for visit:

MEDICAL HISTORY

Name of GP or medical specialist:		
Practice name and location:		
GP or medical specialist contact number:		
Do you see your GP or medical specialist for any medical conditions?	YES	NO
Are you required to take medications/supplements?	YES	NO
Do you have any current or past heart conditions?	YES	NO
History of rheumatic fever?	YES	NO
Lung conditions or breathing problems?	YES	NO
General allergies?	YES	NO

Allergy to medications?	YES	NO
Latex allergy?	YES	NO
Diabetes?	YES	NO
Kidney problem?	YES	NO
Blood disorders?	YES	NO
Hepatitis?	YES	NO
HIV?	YES	NO
Smoking?	YES	NO
Special needs?	YES	NO
Other medical conditions?	YES	NO
If you indicated YES to any of the questions, please provide more detail:		

DENTAL HISTORY

What concerns you most about your teeth?		
History of trauma to some teeth?	YES	NO
Any persistent/prolonged habits such as thumb sucking?	YES	NO
Difficulty swallowing food?	YES	NO
Speech concerns?	YES	NO
Any breathing concerns?	YES	NO
Snoring concerns?	YES	NO
History of teasing due to the appearance of the teeth?	YES	NO
Issues with oral hygiene?	YES	NO
Early loss of baby or adult teeth?	YES	NO
If you indicated YES to any of the questions, please provide more detail:		

Thank you for completing the form.

Signature: _ Date: _

ADDRESS
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WEBSITE
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